

416 - PROVIDER INFORMATION

EFFECTIVE DATES: 10/01/08, 11/01/12, 10/01/13, 05/01/14, 10/01/14, 04/01/15, 07/01/16, 10/01/17, 10/01/18

REVISION DATE: 08/12/10, 10/24/12, 07/18/13, 04/17/14, 07/17/14, 11/01/14, 04/02/15, 04/21/16, 11/01/16, 03/30/17, 04/05/18

I. PURPOSE

This Policy applies to AHCCCS Complete Care (ACC), ALTCS/EPD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. This Policy establishes requirements for Contractors regarding the contents of their provider manual and other provider notification requirements.

II. DEFINITIONS

MATERIAL CHANGE TO THE PROVIDER NETWORK Any change that affects, or can reasonably be foreseen to affect, the Contractors' ability to meet the performance and/or provider network standards as required in Contract including, but not limited to, any change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.

PROVIDER For the purposes of this policy, any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

SUBCONTRACTOR

1. A provider of health care who agrees to furnish covered services to members.
2. A person, agency, or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.
3. A person, agency or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.

III. POLICY

The Contract contains multiple requirements for communications between Contractors and the Contractor's provider network. The list below instructs the Contractor on content and

timing of these communications. The list does not supersede any additional requirements that may be outlined in Contract.

A. PROVIDER MANUAL

The Contractor shall develop, distribute, and maintain a provider manual. The Contractor shall ensure that each contracted provider is made aware of the provider manual available on the Contractor's website or, if requested, issued a hard copy of the provider manual. The Contractor is encouraged to similarly make available a provider manual to any individual or group that submits claim and encounter data.

The Contractor remains liable for ensuring that all providers, whether contracted or not, meet the applicable AHCCCS requirements with regard to covered services, billing, etc.

At a minimum, the Contractor's provider manual shall contain information on the following *(items below apply to all Contractors, with the exception of the items in bolded parenthetical notation. The items in bolded parenthetical notation are Contractor specific and only apply to those Contractors listed)*:

1. The ability of a member's PCP to treat behavioral health conditions within the scope of their practice.
2. Introduction to the Contractor which explains the Contractor's organization and administrative structure.
3. Provider responsibility and the Contractor's expectation of the provider.
4. Overview of the Contractor's Provider Services department and its function, including but not limited to the expected response times for provider calls.
5. Listing and description of covered and non-covered services, requirements, and limitations including behavioral health services.
6. Emergency Department utilization (appropriate and non-appropriate use of the emergency department).
7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers shall document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.
8. Description of dental services coverage and limitations.

9. Description of Maternity/Family Planning services as outlined in AMPM Policy 410 and 420.
10. Criteria and process for referrals to specialists and other providers, including access to behavioral health services.
11. Grievance and Appeal System process and procedures for providers and members.
12. Billing and encounter submission information.
13. Contractor policies and procedures relevant to the providers including, but not limited to:
 - a. Utilization management,
 - b. Claims submission,
 - c. Criteria for identifying provider locations that provide physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities, and
 - d. Primary Care Provider (PCP) assignments.
14. AHCCCS Policies relevant to contractor payment responsibilities including, but not limited to:
 - a. Payment responsibilities as outlined in ACOM Policy 432,
 - b. Description of the Change of Contractor policies. See ACOM Policy 401 and 403 (ACC and ALTCS/EPD), and
 - c. Nursing Facility and Alternative Home and Community Based Service (HCBS) Setting contract termination procedures. See ACOM Policy 421 (ALTCS/EPD and DDD).
15. Reimbursement policies, including reimbursement for members with other insurance as outlined in ACOM Policy 434, and Medicare cost sharing as outlined in ACOM Policy 201.
16. Cost sharing responsibility.
17. Explanation of remittance advice.
18. Criteria for the disclosure of member health information.
19. Medical record standards.
20. Prior authorization and notification requirements, including a list of most frequently used services which require authorization, and instructions on how to obtain a complete listing of services that require authorization.
21. Requirements for out of state placements for members.

22. Claims medical review.
23. Concurrent review.
24. Coordination of care requirements.
25. Credentialing and re-credentialing activities.
26. Fraud, waste, and abuse as outlined in ACOM Policy 103.
27. The AHCCCS Drug List and the AHCCCS Behavioral Health Drug List information including:
 - a. How to access the drug lists electronically or by hard copy upon request,
 - b. How and when updates to these lists are communicated, and
 - c. Information about the tier of each covered drug.
28. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications, including, at a minimum, prior authorization and limits identified in AMPM Policy 310-V, the Contractor's monitoring process for prescribers in AMPM 310-FF, and informed consent requirements in AMPM Policy 320-Q.
29. AHCCCS appointment standards.
30. Requirements pertaining to duty to warn and duty to report as outlined in AMPM 960.
31. Information for behavioral health providers on their responsibilities for submitting to AHCCCS demographic information according to the AHCCCS Demographic and Outcomes Data Set User Guide.
32. Americans with Disabilities Act (ADA) and Title VI requirements, as applicable.
33. How to notify the Contractor and AHCCCS when the provider changes address, contact information or other demographic information.
34. Eligibility verification.
35. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other than English including Sign Language.
36. Peer review and the provider's ability to dispute the peer review process.
37. Medication management services as described in the Contract.

38. The member's rights under 42 CFR 438.100, including:
 - a. A member's right to be treated with dignity and respect,
 - b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand,
 - c. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
 - d. Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable State law, and
 - e. Exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the member.
39. That the Contractor has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102.
40. How to access or obtain Practice Guidelines and coverage criteria for authorization decisions.
41. General and informed consent for treatment requirements.
42. Advanced directives.
43. Transition of members.
44. Encounter validation studies.
45. Incidents, accidents, and deaths reporting requirements.
46. All Contractors except DDD and CMDP shall also include:
 - a. Pre-petition screening, court ordered evaluations, and court ordered treatment.
47. ACC, ALTCS/EPD and RBHA Contractors shall also include:
 - a. Behavioral health assessment and service planning requirements,
 - b. The provider's intake, and referral responsibilities under AMPM Policy 580,
 - c. Requirements for behavioral health providers to assist individuals as outlined in the AMPM Policy 650,
 - d. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to providers under AMPM 1040,
 - e. Serious Mental Illness (SMI) eligibility determination process,
 - f. Partnership requirements with families and family-run organizations in the children and adult behavioral health system, and
 - g. Peer support/recovery training, certification, and clinical supervision requirements.
48. ALTCS/EPD and RBHA Contractors shall also include:
 - a. Housing criteria for individuals determined to have SMI,

- b. Seclusion, restraint, and emergency response reporting requirements, and
 - c. The SMI grievance and appeal process.
49. RBHA Contractors shall also include:
- a. How providers assist DDD and CMDP members served by the RBHA in obtaining a Member Handbook and other new member materials,
 - b. Requirements for grant funded services provided to Special Populations,
 - c. Behavioral health crisis intervention service requirements, and
 - d. An explanation of the process for members not eligible for TXIX/XXI services to file a complaint, grievance, and/or request for hearing when not determined SMI.

B. REQUIRED NOTIFICATIONS

The Contractor is expected to provide written or electronic communication to contracted providers in the following instances:

1. **Exclusion from Network** - Under Federal Regulation 42 CFR 438.12 the Contractor is required to provide written notice of the reason for declining any written request for inclusion in the network.
2. **Material Changes** -The Contractor is required to notify providers in advance of any material change to the provider network and/or business operations as outlined in ACOM Policy 439.
3. **AHCCCS Guidelines, Policy, and Manual Changes** - The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals. In the event of a modification to AHCCCS Policy, guidelines and Manuals, the Contractor shall issue a notification of the change to its effected subcontractors within 30 calendar days of the published change and ensure amendment of any affected subcontracts. Effected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.
4. **Contractor Provider Manual Changes** – The Contractor is responsible for ensuring that its providers are notified when modifications are made to its provider manual.
5. **Subcontract Updates** – In the event of a modification to the AHCCCS Minimum Subcontract Provisions, the Contractor shall issue a notification of the change to its subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.
6. **Termination of Subcontract** – The Contractor shall provide written notice to hospitals and/or provider groups at least 90 calendar days prior to any subcontract termination

without cause. Subcontracts between Contractors and individual practitioners are exempted.

7. Disease/Chronic Care Management – The Contractor shall disseminate information as required by the AMPM Policy 1020.
8. Other communication upon request of AHCCCS. In these instances, AHCCCS will provide prior notification as is deemed reasonable or prudent.